Defense Health Agency - Great Lakes DHA-GL Worksheet-01 Rev. 02/12/2016	MEDICAL ELIGIBILITY VERIFICATION **Reserve Component**

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then faxes or mails this form and supporting documentation to DHA-GL (FAX number / address below).
All blocks must be completed.

PRIVACY ACT STATEMENT

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the Reserve and Service Member Support Office (RSMSO) and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE Program and, E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a (b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

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1. Branch of Service (✓ *one*) ☐ USAR ☐ USNR ☐ USMCR ☐ USAFR ☐ ARNG ☐ ANG ☐ USCGR

2. Name (last, first, MI):	3. Rank or Grade:	4. SSN:

5. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):
	7. Phone Number (xxx-xxx-xxxx):

8. Date of injury/illness (YYMMDD):	9. Treatment occurred on (YYMMDD):	10a. Duty Dates From:	10b. Duty Dates To:

11. Diagnosis or description of injury/illness and/or Pharmacy Claim (include ICD-10 Code):

12. Type of ORDERS (✓ *one*): ☐ Weekend Drill ☐ Annual AT ☐ Other

13. Name of the nearest Military Treatment Facility: _____ which is located _____ miles from the member's ☐ place of duty or ☐ residence (✓ *one*).

14a. Current Unit of Assignment (Unit name, staff symbol, code, etc.):	14b. Current Unit UIC/OPFAC:

14c. Current Unit of Assignment Address (street, bldg #, city, state, & zip):	14d. Current Unit Phone# (include area code):

15a. Unit POC (Med Rep/Unit Administrator) Name, Rank and Title:	15b. POC Phone # (include area code):

16. **Certification**: I certify that this individual is eligible for this care at government expense (CO or Medical Rep. signature):

Signature: Printed Name: Date:

The following documents must be attached:
Documents should match/cover date in block 8 above.

Drill Attendance Sheet or Orders
(for initial date of medical care)

FAX this form/attachments to:
847-688-6460 or 7394
Attn: Reserve Eligibility
Or
MAIL this form/attachments to:
Defense Health Agency Great Lakes (DHA-GL)
Attn: Reserve Eligibility
2834 Green Bay Road Ste 304
Great Lakes, IL 60088